ARKANSAS BETTER CHANCE FOR SCHOOL SUCCESS
CHILD APPLICATION

PRIMARY CAREGIVER INFORMATION
(Parent or guardian with most contact with child)

*Name(First/Middle/Last):		
*Date of Birth:	Home Phone:	Work Phone:
*Current address:		
*City:	*State:	*ZIP Code:
*Employment Status (FT, PT):	Employer Name:	
Employment City:	State:	Employment Zip Code:
*# of hrs per week:	*Education Level (high school, college, etc.)	
If attending school, where:		# of semester hours:
Annual Income From Work Sources or Unemployment:		

SECONDARY CAREGIVER INFORMATION
(2nd Parent or guardian in household with child and is used for determining eligibility)

*Name(First/Middle/Last):		
*Date of Birth:	Home Phone:	Work Phone:
*Current address: ☐ same as Primary Caregiver		
*City:	*State:	*ZIP Code:
*Employment Status (FT, PT):	Employer Name:	
Employment City:	Employment State:	Employment ZIP Code:
# of hrs per week:	Education Level (high school, college, etc.)	
If attending school, where:		# of semester hours:
Annual Income From Work Sources or Unemployment:		

HOUSEHOLD INFORMATION

*Number in Family (The number of immediate family members living in house. (Parent, Guardian, Siblings):	
*Number in Household (The total number of people living in the house):	
List the name and relationship to the child enrolled of all family members in the household:	
Name:	Relationship:

***Must be entered into COPA.**

Child Information

*Name(First/Middle/Last):		
*Date of Birth:	*Social Security Number:	
*Gender:	*Ethnicity:	*Primary Language:
Has this child attended a state-funded pre-K (ABC) program before? ☐ Yes ☐ No	If so, where?	
Will this child be concurrently enrolled in an ABC center and HIPPY or PAT program? ☐ Yes ☐ No	If so, which HIPPY or PAT?	
List any allergies:		
Does the child have any special dietary needs?		
Receiving any special education services?		
Primary Language:		

Emergency Contact and Consent Information

Name of emergency contact if parent/guardian cannot be reached:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		
Physician Name:		
Address		Phone:
City:	State:	ZIP Code:

Consent for Emergency Medical Care

I _____ _____ of _____

Parent/Guardian's name — Relationship — Child's name

Do hereby request and give consent to the Director/Caregiver of the Child Care Facility, or their duly appointed representative, for said child to receive such medical or surgical aid as may be deemed necessarily expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parent(s) cannot be reached. Consent is also given for the Director/Caregiver or their duly appointed representative to transport said child for emergency medical treatment, if parent(s) cannot be reached. I additionally give consent for my child to attend the above named field trip.

_____ _____

Parent/guardian signature — Date

Signature

I declare under the penalty of perjury and the rules and regulations of the Arkansas Better Chance program that the information supplied is true and correct at the time of application. I understand that the information I supplied may be independently verified by the Arkansas Division of Child Care and Early Childhood Education and that any false statements may result in exclusion from DHS programs and criminal prosecution.

Signature of Primary Caregiver:	Date:

***Must be entered into COPA.**

Additional File Information

Primary Caregiver (Circle one answer or write in answer)

Name:_____

Gender: Male Female

Language: English Spanish Other

Food Stamp/SNAP: Yes No

Race: _____

Township:_____

County:_____

Marital Status: Married Single Divorced Widowed Separated Other

Disabled: Yes No

Current Housing: Homeless Own Rent Other

Current Housing Date: (Day you moved in)_____

Has Family Moved in 24 Months: Yes No

Member of US Military on Active Duty: Yes No

Secondary Caregiver (Circle one answer or write in answer)

Name:_____

Gender: Male Female

Language: English Spanish Other

Race: _____

Marital Status: Married Single Divorced Widowed Separated Other

Disabled: Yes No

Member of US Military on Active Duty: Yes No

Child Information (Circle one answer or write in answer)

Name:_____

Primary Language: English Spanish Other

Speak English at Home: Yes No

English Skills: Very Well Well Not Well Not at All

US Citizenship: Yes No

Parental Status: Two Parents Single Parent

Medical Insurance: Yes No

Specify Medical Insurance (if applicable):_____

Current School District: (Where resides 50% of time) _____

Child's Medical & Dental Home

Child receives medical services through

_____ Ongoing source of continuous accessible medical care (Medical Home)

_____ Indian Health Servies

_____Migrant Community Health Center

Program verification date (child up to date status) _____

Primary reason for NOT receiving treatment_____

Child receives an ongoing source of Continuous Dental Care (Dental Home) _____

Is the child up to date on a schedule of age appropriate Preventive and Primary Health Care including all appropriate tests and physical exams? _____

Up to date at enrollment (based on EPSDT schedule) _____

Health Care Prof. Verification Date (Child up to date status) _____